NOVEMBER 1950

In This Issue:

DENTISTRY ON TIME

DENTAL HYGIENE

Greater New York Dental Society Meeting, New York City, December 4-8.

Interchangeable Sheaths Impress the Patient as a Sanitary Precaution

You can have **one to 100** sterilized sheaths to use as each patient is seated. Just snap the sheath into place *without adjustment.* Think of the favorable impression created by this move—possible *only* with *SANI-TERRY HANDPIECES.*

SANI-TERRY HANDPIECES reduce the discomfort of the patient and lessen the fatigue of the dentist. They are true-running, smooth in operation and free of unnecessary vibration. Work proceeds more rapidly because of the freedom from strain.

Due to the fact that weight is balanced at the point where the handpiece is naturally grasped, *SANI-TERRY HANDPIECES* cause no backward drag on the operator's wrist.

CLEVE-DENT CONTRA-ANGLE U

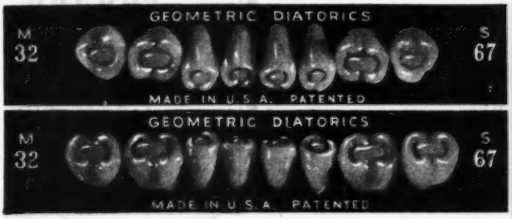
The *CLEVE-DENT CONTRA-ANGLE U* may be used with the *SANI-TERRY HANDPIECE* if preferred. It fits accurately over the handpiece and is free from unnecessary vibration.

a variety of posterior teeth

GEOMETRIC POSTERIORS

have no cuspal inclination whatsoever.

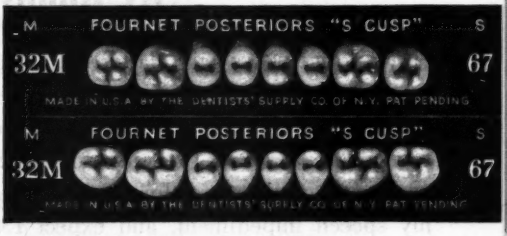
Geometric Posteriors are the popular "flat plane" teeth. They minimize the possibility of trauma due to lateral displacement of the dentures, and they do not cause malocclusion when the underlying tissues change. They were designed by J. B. LaDue, D.D.S. and J. A. Saffir, D.D.S.



FOURNET POSTERIORS

have anatomical cusps and ridges and function like flat posteriors.

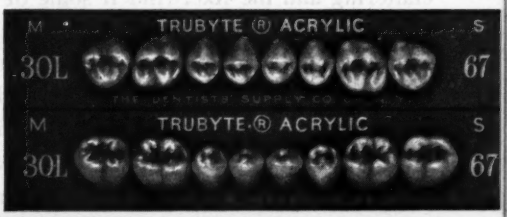
In function, the cusps of the uppers ride the ridges of the opposing teeth without interference. In centric, cusps and sulci mesh perfectly. Because they are narrow linguobuccally, Fournet Posteriors can be set on the ridge. Stability is thereby improved and there is less tendency for the tongue to dislodge the denture. Fournet Posteriors are available with two cusp depths — shallow and deep.



TRUBYTE® ACRYLIC POSTERIORS

are made in the popular Trubyte New Hue 33° Moulds.

Trubyte Acrylic Posteriors are suitable for full and partial dentures opposing natural teeth, and for full dentures opposing acrylic teeth. They're easy to articulate. They have a natural lingual and buccal anatomy.



DEALERS AND LABORATORIES EVERYWHERE

The Publisher's CORNER

By Mass

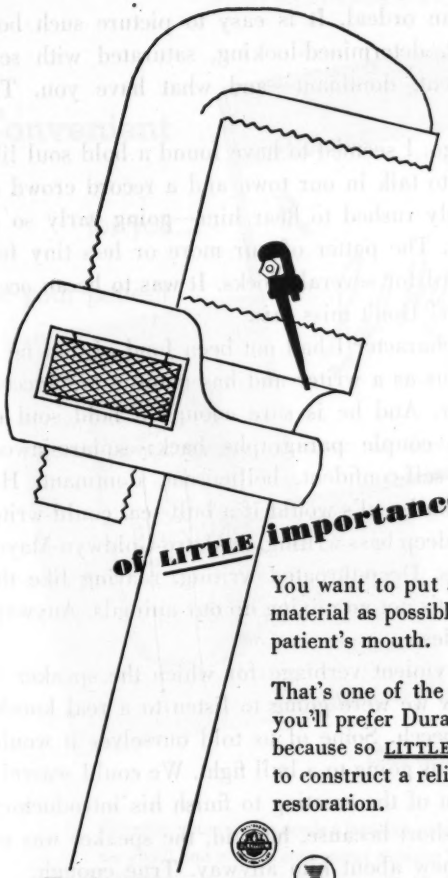
No. 352

My Buddy

HAVE YOUR KNEES ever clattered like castanets? Have you ever had black spots before the eyes? Have you ever had hot and cold flashes? Along with clammy hands? In short, have you ever made a speech? In my fortunately infrequent platform appearances, I have suffered all these ailments, in addition to my speech impediment, and expect I shall continue to suffer them every so often until I die.

You dentists, what with dental society and study club and other meetings, have many more opportunities than I for knee-clattering and the like. And if some of my speech-making dentist friends have been truthful about it, despite at least fairly frequent public appearances they suffer at least some of the ailments I have described. In fact, I don't recall ever having heard any of them deny that, at least in the early stages of a talk, he has not been a victim of logoes-on-the-bogoes.

Still, there must be some people who don't turn a hair—who



of LITTLE importance

You want to put as LITTLE material as possible into a patient's mouth.

That's one of the reasons why you'll prefer Durallium: because so LITTLE is required to construct a reliable restoration.

Write for details on Durallium
...or ask your Durallium laboratory

durallium

products corp.

809 W. WASHINGTON BLVD. • CHICAGO 7, ILLINOIS

don't find oratory an ordeal. It is easy to picture such bold souls. Square-jawed, determined-looking, saturated with self-confidence, belligerent, dominant—and what have you. The lucky lugs.

Not many days ago, I seemed to have found a bold soul like that. He was billed to talk in our town and a record crowd of us almost breathlessly rushed to hear him—going early so as to be sure of a seat. The patter of our more or less tiny feet could have been heard for several blocks. It was to be an occasion, no less. Brother! Don't miss *this*.

The speaker is a character I had not been fond of, but he is internationally famous as a writer and has made a big success of his writing career. And he is sure enough a bold soul of the sort pictured a couple paragraphs back: square-jawed, determined-looking, self-confident, belligerent, dominant. His writing barks like a bull seal's would if a bull seal could write. Deep bass barking—deep bass writing. A Metro-Goldwyn-Mayer lion look in his eyes. Deep-throated writing, roaring like the M-G-M lion's—but let's not go mixing up our animals. Anyway, I think you get the idea.

Remembering the violent verbiage for which the speaker is famous, we just knew we were going to listen to a real knock-down-and-drag-out speech. Some of us told ourselves it would be almost as thrilling as going to a bull fight. We could scarcely wait for the chairman of the meeting to finish his introductory remarks. They were short because, he said, the speaker was so famous everybody knew about him anyway. True enough.

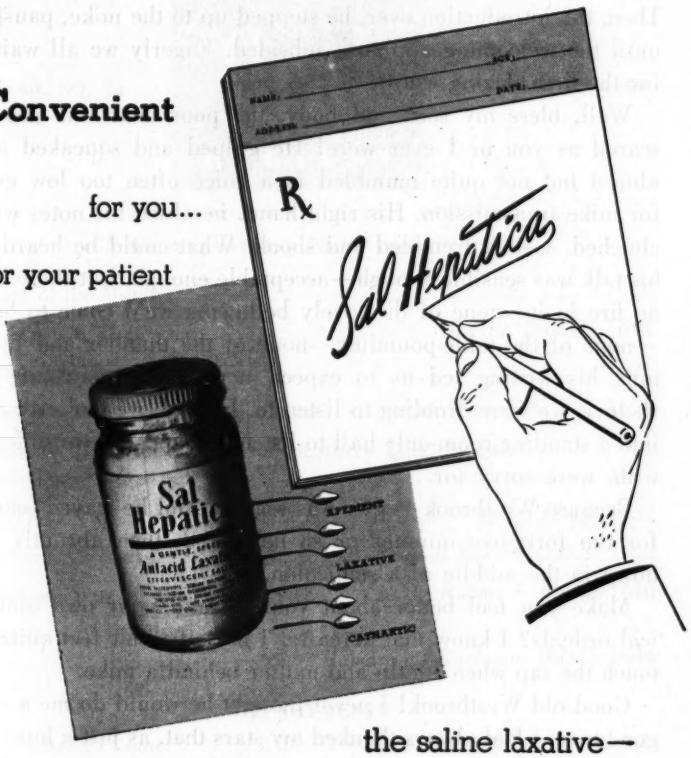
Meanwhile, the speaker had been sitting on the platform for a while and we cowered under his piercing glance as he directed it hither and yon. Blond John L. Lewis eyebrows helped the piercing-glancing.

He looked every inch of him the fearsome figure we had pictured. As the seconds ticked off, every local yokel of us, I

Convenient

for you...

for your patient



the saline laxative—

Whether your patient needs a laxative, or an aperient, or a cathartic you'll find it more convenient to write SAL HEPATICA on your prescription pad. No need to specify all the ingredients of three separate formulas, just prescribe SAL HEPATICA and indicate the dosage.

Your patients will find SAL HEPATICA convenient, too. No cluttering of shelves with bottles of different laxatives when one will serve. They'll like its pleasant taste, its effervescence—and, of course, its prompt, gentle action.

a product of BRISTOL-MYERS • 19 West 50 Street, New York 20, N. Y.

think, must have envied the fearless power of this sturdy gent. Then, the introduction over, he stepped up to the mike, pausing until the welcoming applause subsided. Eagerly we all waited for the first blazing word.

Well, bless my soul and body, the poor dear was just as scared as you or I ever were! He gulped and squeaked and almost but not quite mumbled in a voice often too low even for mike transmission. His right hand, in which his notes were clutched, visibly trembled and shook. What could be heard of his talk was sensible enough—acceptable enough. But there was no fire in it—none of the lovely bellowing we'd come to hear —none of the table-pounding—none of the thunder and lightning his writing led us to expect, none of the raus-mit-'em rhetoric we were drooling to listen to. Instead, we had crowded into a standing-room-only hall to listen to a speaker we suffered with, were sorry for.

Because Westbrook Pegler was scared. And he stayed scared for the forty-five minutes or so he talked, then abruptly sat down in the middle of a semicolon.

Make you feel better about yourself and your own oratorical ordeals? I know that hereafter I myself won't feel quite so much the sap when I gulp and mutter behind a mike.

Good old Westbrook! I never thought he would do me a real good turn. I had always thanked my stars that, as just a humble, everyday citizen, I wouldn't be one he'd ever get around to denouncing. Maybe he will now, though, if he chances to read this CORNER—which doesn't seem likely. I hope not. Because although he'll likely never know it, Westbrook is a buddy of mine now. And a buddy of all the other poor, frightened occasional orators whose souls he soothed that day.

VOL. 40, NO. 11

Oral HYGIENE

NOVEMBER 1950

REGISTERED IN U.S. PATENT OFFICE

Circulation more than 70,000 copies monthly

DEPARTMENTS

EDITOR
Edward J. Ryan
B.S., D.D.S.

ASSOCIATE EDITOR
Marcella Hurley
B.A.

EDITORIAL OFFICE: 708 Church Street, Evanston, Ill.; PUBLICATION OFFICE: 1005 Liberty Avenue, Pittsburgh 22, Pa.; Merwin B. Massol, Publisher; W. Earle Craig, D.D.S., Associate; Robert C. Ketterer, Publication Manager; Dorothy S. Sterling, Promotion Manager; Homer E. Sterling, Art; Norbert Drol, Circulation Manager. NEW YORK: 7 East 42nd Street; Stuart M. Stanley, Vice President-Eastern Manager. CHICAGO: 870 Peoples Gas Building; John J. Downes, Western Manager. ST. LOUIS: Syndicate Trust Building. LOS ANGELES: 1709 West 8th Street; Don Harway, Pacific Coast Manager.

Clinically Proven*

PROMOTES FIRMER, HEALTHIER GUMS

You know the importance of healthy gums. You know more teeth are lost from neglected gums than tooth decay. So won't you continue to recommend Forhan's with massage for firmer, healthier gums and as a valuable home adjunct to your professional treatment in Gingivitis?

'Double-Purpose' Forhan's for cleaner teeth and gum massage

*Impartial clinical tests prove Forhan's with massage effective in 95% of Gingivitis cases and 100% efficient in maintaining healthy gums.

For professional samples, mail this coupon TODAY

Forhan Division, Zonite Products Corp.
New Brunswick, N. J.
Please send free samples for patients.

NAME.....

STREET.....

CITY:..... STATE.....

Picture of the Month

DOCTOR Nat G. Slaughter (facing camera at left), former State Senator from Athens and Past President of the Georgia Dental Association, looks on with Dean Virgil Eady of Emory University as old graduates welcome alumnus Vice President Alben Barkley back to the Oxford, Georgia, campus after an absence of fifty years.—*Photograph submitted by Mrs. N. G. Slaughter, 1490 Prince Avenue, Athens, Georgia.*

Ten dollars will be paid for the picture submitted and used in this department each month. Send glossy prints with return postage to ORAL HYGIENE, 708 *Church Street, Evanston, Illinois.*

This Sensationally New

Kerr Flamette

ALCOHOL TORCH

(Patent Applied For)

at 'NO COST' to You!

THE TORCH

See How You Can Actually Save Money and Still Own This Amazing Torch

Here's what you get when you buy the Kerr Impression Compound Bonus Package—

22 Boxes of Kerr Regular Impression Compound Cakes (Red)	$17.60
1 Kerr Flamette Torch	4.50
Total Value	22.10
BONUS PACKAGE PRICE	16.75
HERE'S WHAT YOU SAVE	$ 5.35

In effect, you get the Flamette Alcohol Torch *at no cost*—and actually save money on your purchase of the World-Leading Kerr Compounds.

Only a brand new principle hooked up with volume production makes this possible!

And what a Torch!

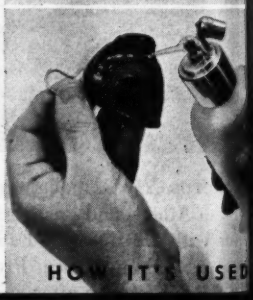
See the body of the Flamette? It's flexible plastic. Press it gently—out comes a sharp Pin-Point Flame.

Light-weight . . . very maneuverable . . . and accurate too—A real pleasure to own and use!

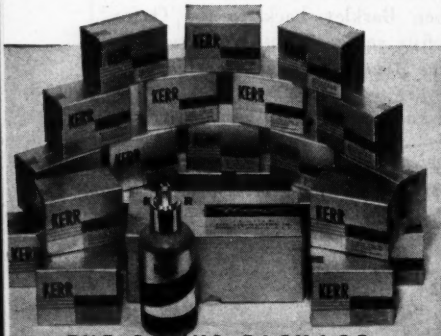
And it's yours at "no cost" while they last . . . Phone your dealer today and ask him—"How about that Kerr Impression Compound Bonus Package?"

KERR MANUFACTURING CO.

Detroit-8 ***Established 1891*** **Michigan**

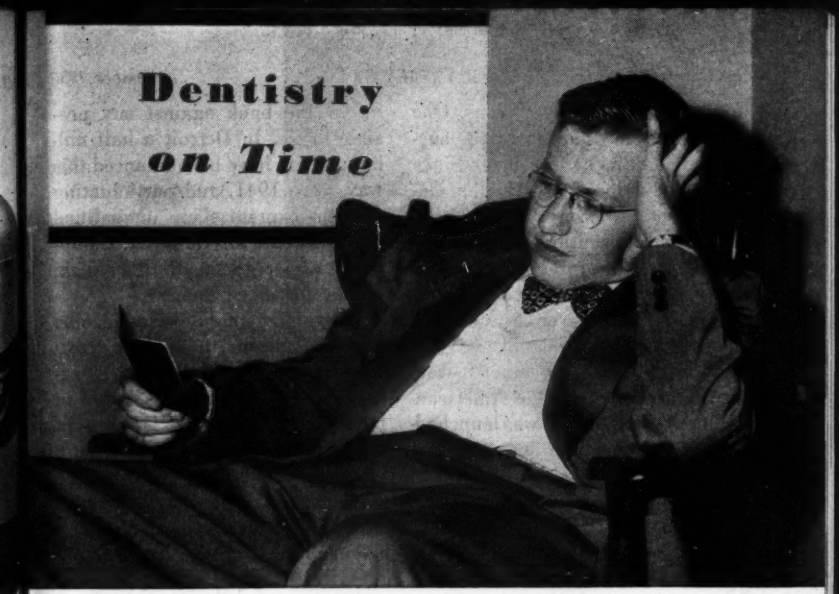


HOW IT'S USED



THE BONUS PACKAGE

KERR IMPRESSION COMPOUND BONUS PACKAGE



PROBLEM:
Typical young American family man suffers from pain and pocketbook. He needs dental care urgently, but worries over low bank account.

BY GORDON DUNCAN

THANKS TO ethical budget payment plans, fewer people today have to postpone dental repairs because of cost. Yet, too many potential patients are still unaware that they can finance dentistry conveniently.

Not that Americans aren't credit conscious! Today, both low and medium income groups use time payments to get immediate goods and services which otherwise would not be available for some time, if at all. The dentist's chief competition is not another dentist, but the salesman for radio and television sets, refrigerators, and automobiles. Financing has done much to give the American his high standard of living. With today's spiraling living costs, many of us must dig into regular earnings—not savings.

Nine-year test in Detroit established the value of budget dentistry for low and middle income groups.

For years, banks in various cities have been offering personal loan plans to help finance dental accounts, and many regional dental associations have worked out dif-

ferent types of budget plans. One of them is outstanding for its successful working arrangement. Since its introduction in 1941, the Detroit Dental Society Payment Plan has matured cautiously, but consistently. During the last several years, the plan has been adopted successfully by over a score of other cities and towns all over the country, and last November it won the full approval of the American Dental Association. It was launched only after thorough investigation of some 65 other dental payment plans, most of which have fallen into disuse through their inherent faults.

The Detroit Plan

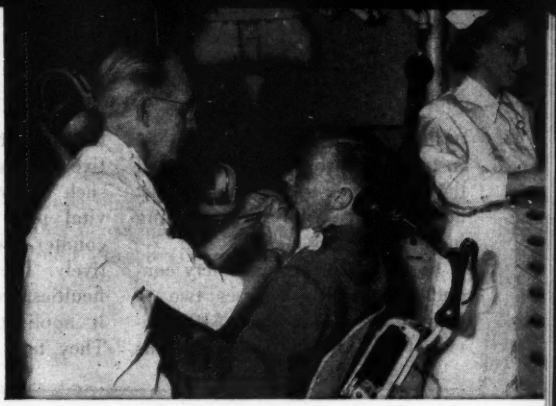
In general, this is Detroit's plan: The patient is examined, an estimate of the fee is made, and the dentist and patient map out a satisfactory budget arrangement. Next, the patient fills out a credit application and note which are mailed to the local commercial bank cooperating with the society. From here the bank takes over, first investigating thoroughly the patient's credit rating. If the loan is approved, a bank financing charge is made. The 8 per cent charged in Detroit includes life insurance on any balance due, and this group sets a minimum of $100 for loans, with 18 months maximum time for payments. The loan is then handled without recourse to the dentist, since a 5 per cent reserve on everything financed has been set up by the bank against any possible losses. In Detroit a half million dollars have been financed this way since 1941, and participating dentists express their unqualified approval. Doctor Ralph H. Campbell, who pioneered the plan, speaks for all of them:

"By giving middle-class income groups a means to pay for treatment by installments through a regular commercial bank instead of in large sums, dentistry is brought within the economic range of many more people."

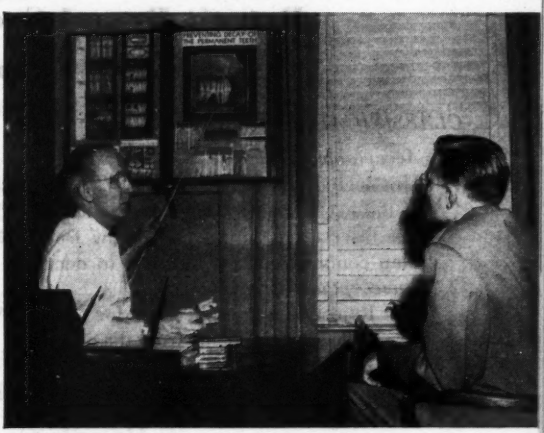
As a result of the Detroit group's trial-and-error experience, its members now can offer invaluable tested hints on the operation of a good dental plan. One of their primary recommendations is that participating members should be in good standing with their local dental society. If a dentist is dropped from membership, the participating bank must be notified immediately. Such strict control by the society is fundamental, and is maintained in Detroit by electing six society members as policy directors for three-year terms, with two terms expiring each year. Vacancies are filled by Council elections. Over seven hundred of the Detroit Society's 1,350 members are eligible to use the plan.

Doctor Frank Koepel, chairman of the Detroit Dental Society Payment Plan, makes another suggestion:

"Before any dental society takes up a time-payment plan, every



STEP NO. 1
Relief: Doctor Roy Fonda furnishes temporary relief from pain.



STEP NO. 2
Attention: Dentist explains source of patient's dental disease.

STEP NO. 3
Educatio[illegible] Patient [illegible]ns what must be done and then how it can be financed conveniently.

participating dentist should be instructed thoroughly in the use of the plan, since the average dentist does not have a thorough training in such business methods."

For this reason the society conducts instruction courses two to four times a year for a $10 individual fee. In two-hour sessions the instructor and bank representative discuss details of the plan, and such underlying principles as the vital part the plan can play to counter socialized medicine effectively. They go into possible difficulties, and all the details of credit applications and note forms. They talk over the best ways of

---

Detroit Dental Society

Payment Plan

CLASSIFICATION OF CREDIT

1. *Acceptable Credits*
   This includes marginal credits. The dentist is advanced 95 per cent of the net amount of loan; the balance of 5 per cent to be held as loss reserve for the account of the Detroit Dental Society Payment Plan commission. No recourse to dentist.
2. *Unacceptable Credits*
   (a) Rejection of application for credit. Accounts which will be collection problems from the outset are unacceptable.
   (b) Collection account. Where applicant's credit does not warrant advance of depositors' funds, but offers a possibility that the account will be paid, applicant's note may be accepted on a collection basis. No funds are disbursed when the loan is made. Monthly remittances on the 7th of each month are made to the dentist as collected from the patient. Interest costs are deducted from the first collection.

RATES AND TERMS

1. Maximum time 18 months. Minimum loan $100. Minimum monthly payments $5. Minimum charge $5.
2. Eight dollars per $100 per year, which includes life insurance on any balance due on loan.

CREDIT STATEMENT

The Credit Statement or application is designed to include all pertinent facts necessary to favorably determine the applicant's request for credit. It may be telephoned, mailed, or delivered to any office of the bank.

CREDIT INVESTIGATION BASED ON:

1. Records—Time Credit Department, The Detroit Bank.
2. Clearance through all other banks making this type of loan.
3. Michigan Merchants Credit Bureau (Credit Bureau of installment houses).
4. Existing debts.
5. Number of dependents.
6. Length of residence.

ADVICE OF CREDIT DECISIONS

1. By telephone to dentist.
2. Rejection of application and review with dentist of reasons for refusal.

DISBURSEMENT

1. Execution of Dentist's Reserve Agreement (once only).
2. Proper execution of note—endorsement of dentist.
3. Advance to dentist of 95 per cent of the net amount of the loan. The balance of 5 per cent to be held as a loss reserve.
4. Statement with breakdown of costs.
5. Collection account 7th of each month by check with statement of accounts covered.

COLLECTION PROCEDURE AND POLICY:

1. General Routine
   (a) New loans—first payment not made.
      1. Credit file examined to discover possible reason for delinquency.
      2. Telephone call if possible. If not, special letter.
      3. Personal call if necessary.
   (b) Seasoned loans
      1. Routine delinquent notice; 6, 12, and 18 days.
      2. Telephone calls.
      3. Special letters.
      4. Personal calls.
2. Special procedure on notes handled on a collection basis, attorney letters.

SUMMARY

1. Extent of cooperation on part of bank.
2. Necessity of cooperation on part of dentist.

STEP NO. 4

Acceptance: As Mrs. Evelyn Irwin, dental assistant, explains details of budget plan, the patient fills in application form.

STEP NO. 5

Procedure: Next dental appointment is made willingly.

STEP NO. 6

Conclusion: Signed and sealed, the whole transaction has taken only fifteen minutes.

presentation and use of the plan in individual offices. Then each dentist is given a printed resumé of the plan, with an explanation of the forms used. This helps him obtain prompt credit decisions with a minimum of disturbance to the patient. In most cases, reports Doctor Koepel, the entire transaction can be handled in the dentist's office with no co-signers needed. Thus, the dentist is relieved of all collection details and the attendant difficulties and embarrassments.

Local experience has convinced the Detroit group that dentists will not advocate any financing plan where the feature of recourse is retained. For that reason, the dentist gets 95 per cent of his fee immediately, with no recourse attached. But, do most patients respect the entrance of a third party into their transactions? Yes, especially when the party is an established commercial bank. In fact, it is well affirmed that a person is more likely to make payments to an ethical bank on a specified date than to another person. Detroit's nine years' experience with the plan also bears out what has long been established by banks and finance companies everywhere; namely, that if reasonable credit is extended after thorough investigation, the average collection is no less than 98 per cent to 99 per cent!

Aids Family Treatment

Let us consider a typical case of the plan's use in Detroit. Last spring a man brought in his family of four to Doctor Roy Fonda's office for a complete checkup. Unaware of the possibility of budget payments, he was a bit worried; especially after Doctor Fonda's examination disclosed that the man, his wife, and the two youngsters all needed prompt dental treatment. Checking with his appointment book, the dentist asked pleasantly who wanted to be first.

The father, obviously concerned with the matter of payment of fees, nodded to his wife. "You first, ma." But ma shook her head. "You're the head of the family, pa."

Doctor Fonda, glancing over at the two children, explained to the parents that if a choice were necessary, the younger generation's teeth should perhaps get priority, and mother and father agreed readily. But then the dentist smiled and pulled out his ace card. "How would it be," he asked, "if I took care of all four of you at the same time; that is, on the same visiting dates?"

They were surprised and Doctor Fonda explained that perhaps budget payments could take care of the total $200 fee. "That's twenty dollars a month for ten months, or five a week," he began. "In other words, could you afford $1.25 a week for each member of the family?"

Presented in such a manner, both parents were pleased. As the

★ ★ ★ ★ ★ ★ ★

ORAL HYGIENE AWARD

This article by GORDON DUNCAN has won the $100 ORAL HYGIENE award for the best feature published this month.

★ ★ ★ ★ ★ ★ ★

dental assistant went into budget details, the application and note forms were drawn up then and there. The dentist reminded the parents, too, that by their coming in all together, the family would gain not only the advantages of prompt treatment, but also would save on transportation expenses; for they lived on the other side of town.

America's dentists are getting used to the budget payment plan gradually. With the American Dental Association backing it, Detroit's plan can fill a definite need, according to Doctor Fonda, who deserves no small credit for the expansion of the plan to new communities. Lecturing in his free time to interested dental groups from coast to coast, he illustrates how much-needed dentistry can be brought to America's middle income group through "this positive approach to the threat of socialized medicine." And this, contends Doctor Fonda, "is just self-preservation!"

The plan should not grow too fast, points out Doctor Koepel. "Dental financing is still in its infancy, and no one should expect too much too soon. But our plan is built on a solid foundation, and we're happy to see it working out so well in other parts of the country at such a vital time."

Is there a Dental Payment Plan operating in your community? If not, full details on organizing a budget plan are available from the American Dental Association headquarters at 222 East Superior Street in Chicago, Illinois.

409½ Saginaw Street
Saginaw, Michigan

THE COVER

THE COVER this month is a typical New York City night scene and is dedicated to the Greater New York Dental Meeting which will be held at Hotel Statler (formerly Hotel Pennsylvania), December 4-8. The photograph was taken by Homer Sterling, ORAL HYGIENE'S staff photographer.

With his hand on the throttle, Doctor Hooper keeps a careful watch on the model trains as they respond to the various switches at his command. —Durham Daily Herald photograph.

Railroading Dentist

YIELDING TO his father's wishes that he become a dentist, Doctor G. L. Hooper of Dunn, North Carolina, had to forego his childhood dream of becoming a railroad man like his father, who was with the Southern Railway for 52 years. But the fact that he never worked on a railroad by no means lessened Doctor Hooper's love for trains. When his son was two years old he bought him a big standard gauge model train, the beginning of the

"Swift Line Railroad," one of the most elaborate model train layouts in the country.

At the insistence of Mrs. Hooper, this first train was removed from the upstairs hall of the Hooper home to a room of its own. Then started the expansion of the "Swift Line" to the twelve complete trains covering a huge table which fills the room. In fact, Doctor Hooper's collection includes every piece of rolling stock and accessory that Lionel makes. The entire network is engineered through a six-foot control panel equipped with a mass of levers, buttons, and switches.

Not all of the trains are on the same level. Two operate on an elevated track on a trestle above ten others which operate through a complicated maze of track and accessories in the toy village below. The village, including houses, roads, automobiles, and even pedestrians, is built on the table between the tracks. On the river which flows underneath the automatic drawbridge is a ferry boat carrying a number of automobiles, and along the streets and railroad tracks are lights similar to those which light real-life thoroughfares. The drawbridge automatically stops the train approaching it, holds the train until the bridge is lowered, and then allows it to continue.

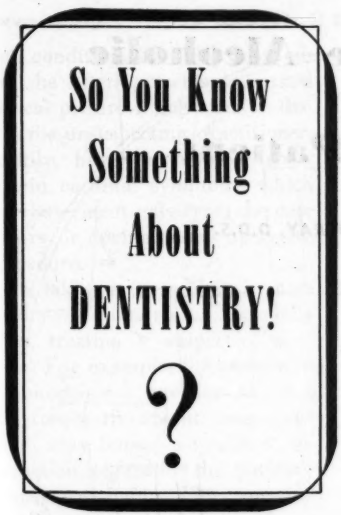
On one stretch of track there is a cattle pen from which cattle load onto the train and unload again, with just the press of a button. The cattle can be stopped inside the cattle car, or may be allowed to pass through the door at one end and back into the cattle pen again at the other end.

Coal-loading and log-loading devices as well as water tanks, flood light towers, innumerable switches, crossings, lights, sidings, and railroad accessory buildings are situated along the route.

One of the most unique accessories on the table is a talking railroad station. With the press of a button on the major control panel the conductor announces the departure of a limited train for Philadelphia and New York. As soon as the conductor concludes with "'Board!" the train moves out of the station. At another stop, a man aboard the train unloads five milk cans onto a platform beside the tracks.

Doctor Hooper is one of the 20,000 members of the National Model Railroad Association, an organization of model train enthusiasts. He also prints and issues passes to his friends and to celebrities for trips aboard the "Swift Line Railroad."—*Clarence E. Whitefield, Durham (North Carolina) Morning Herald.*

So You Know Something About DENTISTRY!



QUIZ LXXIV

1. Enamel hypoplasia of the deciduous teeth is found most frequently (a) on the upper incisors, (b) on the cuspids, (c) on the cuspal surfaces of the molar teeth. _____

2. When chloroform evaporates from a gutta percha and chloroform root canal filling there is (a) no change, (b) a mild change, (c) a significant change, in the volume of the root canal filling. _____

3. What are mucin plaques? _____

4. The condylar angle (a) widens, (b) narrows, (c) shows no change, after loss of all teeth, especially if no denture is worn. _____

5. Gingivae and soft tissues of the mouth show (a) a greater, (b) less, (c) the same, tolerance to cobalt-chrome alloys when compared to gold alloys.

6. In testing saliva for lactobacilli, should saliva be collected within two hours after eating?

7. Can the needle be inserted into the canal in the intra-oral method of the infra-orbital injection? _____

8. Is impaired hearing a common result of multiple loss of teeth?

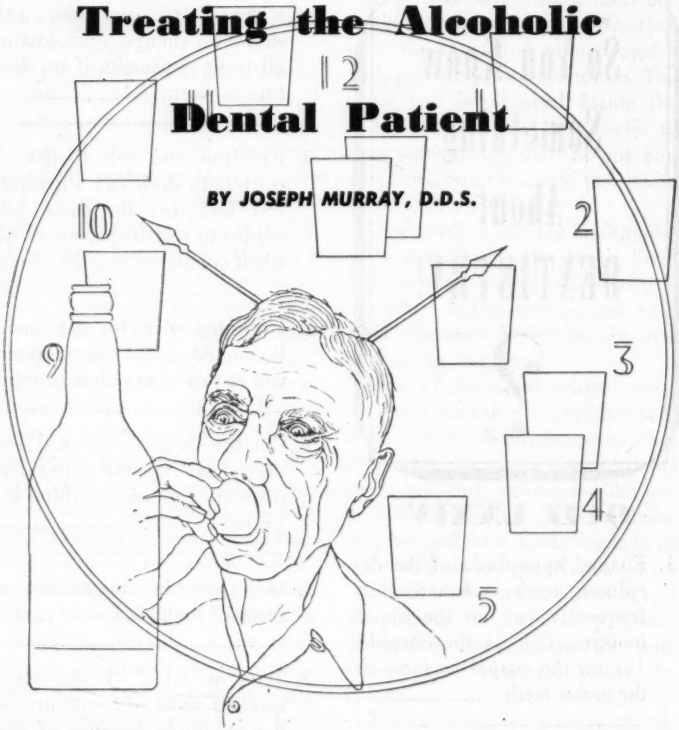
9. True or false? Acute osteomyelitis most often occurs in the mandible because of the dense bone, whereas the cancellous nature of the maxilla favors drainage and recovery.

10. The (a) square, (b) tapering, (c) ovoid, anterior tooth is best adapted to the application of the anterior three-quarter crown. _____

FOR CORRECT ANSWERS SEE PAGE 1650

Treating the Alcoholic Dental Patient

BY JOSEPH MURRAY, D.D.S.



Understanding the symptoms of alcoholism facilitates the recognition and correct treatment of the chronic drinker.

IT IS ESTIMATED that in the United States alone, there are about four million people who, by medical standards, drink too much for their own good. Now, what has this state of affairs to do with the dentist?

Simply this: A large number of these people are your patients and mine. And, especially when they are problem drinkers, they present a threat to the serenity of our dental practices. Incidentally, a problem drinker is one who takes a drink for some compulsive reason he cannot identify, and, having taken it, is unable to stop before he is intoxicated.

Unfortunately for the dentist, the alcoholic patient rarely walks into the dental office in an inebri-

ated condition. Like the drug addict, he often presents a normal clinical picture which tends to disarm the unsuspecting practitioner. Luckily, however, he does show certain cardinal symptoms which may be evident only from the case history or during actual operative procedure.

So, taking a comprehensive case history is important, especially when treating a suspected alcoholic. For example, the answer to so innocuous a question as "Are you frequently absent from your job?" may impart a wealth of information regarding the patient's temperance habits. The question of absenteeism in industry is so vital that many large firms are establishing their own programs for diagnosis and treatment, and are taking a keen interest in medical research aimed at discovering the still unknown causes underlying chronic alcoholism.

It follows then, that loss of time on a job because of intemperance will be reflected in broken dental appointments and consequent disruption of the dentist's practice.

Frequently, the alcoholic has dietary deficiencies because he consumes liquor instead of food. "How's your appetite?" is a good leading question and a negative response should put a practitioner on guard. "Do you take tonics often?" should elicit an indicative reply.

The answer to "How's your liver?" can also give the dentist a clue during history-taking, because alcoholics frequently develop cirrhosis of the liver.

The inveterate drinker often feels hopeless; consequently, he usually has a pessimistic outlook. He may even wish to have all his teeth extracted although they could be saved. The chronic drinker is considered a psychopathic personality and may be driven to constant and repetitious lying and stealing. Because of his emotional instability he is also a poor credit risk.

At times suicidal tendencies grip the alcoholic. He may turn sadistic; and, because of his inner conflicts, may desire to humiliate his dentist, complain of his ability, or actually desire to hurt him by word or deed.

Like the drug addict, the problem drinker can be an operative hazard because he may get "fighting mad." Do not use a general anesthetic for this patient unless you are skilled in its administration. It is better to give local or conductive anesthesia, or send him to an oral surgeon for extraction.

The alcoholic may seem to be irresponsible, undependable, insincere, egocentric; a waste of human energy. Yet, basically, he may be talented and have great potentialities.

Basic anxiety is the underlying cause of alcoholism and the source of alcoholic neurosis, a name given to the aggregate feelings of hopelessness, isolation, hostility, and

lack of confidence. People develop these feelings early in life as a result of unfavorable inter-personal relationship with the significant persons in their environment.

A father may be a stern, autocratic perfectionist, demanding strict obedience from the child who fears him. The mother is frequently compliant, overprotective, secretly acknowledging his superiority. The child, as a result, has no chance to develop his real self. His energies are directed now only for survival—not toward satisfying growth and real security.

Once I had a patient who believed in spiritualism. "I must commune with the spirits before I visit the dentist," was her usual lament. Unfortunately, those spirits were liquid, making it necessary for my assistant to feed her black coffee to restore her equilibrium.

When a woman patient begins to shed spontaneous tears, she is either an alcoholic, a neurotic, or both. Perhaps she is misunderstood, although the chances are that lack of sobriety is the underlying cause.

At any rate, whether alcoholism stems from psychologic sources, or is due to metabolic disturbances, as believed by Doctor James J. Smith of Bellevue Medical Center at New York University, the liquid bearing artificially induced elation is here to stay. Dentists should become reconciled to treating the drinker and adopting the philosophic slogan of Alcoholics Anonymous which brings its members peace of mind: "God grant me the serenity to accept things I cannot change, courage to change things I can, and the wisdom to know the difference."

1358 *Forty-Sixth Street*
Brooklyn, New York

SELECTIVE SERVICE REGISTRATION OF DENTISTS

ACCORDING TO a Presidential proclamation, every dentist who has not reached his 50th birthday must register with Selective Service boards before January 15, 1951. The first group of registrants on October 16, 1950 included all dentists trained at government expense during World War II who spent less than 21 months in active service, or were deferred to complete their professional training.

All other dentists under 50 years of age, whether they are in practice or not, are required to register at a date set by the Director of Selective Service, but no later than January 16, 1951.

New graduates are directed to register upon the date of their graduation or within five days thereafter. Dentists registered under the Selective Service Act of 1948 are required to re-register. Reserve officers and other members of the National Guard and other reserve components are *not* required to register.

A Map Showing Location of Dental Societies Enrolled in the University of Illinois College of Dentistry Long-Distance Telephone Course

(Map on following pages)

The dots on the map on pages 1628-29 represent the locations of dental societies in the United States and Canada that are enrolled for the second series of lectures in the University of Illinois College of Dentistry long-distance telephone course that begins on November 13.

As an added and timely feature in this series short talks will be given on aspects of emergency first-aid treatment by outstanding authorities in the medical world. Such information will be given to dentist listeners to help prepare them for first-aid service in the case of an enemy attack or civilian catastrophe.

ALABAMA
Dothan
Gadsden
Montgomery
Tuscaloosa

ARIZONA
Tucson

ARKANSAS
Fort Smith
Little Rock
Rogers

CALIFORNIA
Bakersfield
Fresno
Long Beach
Los Angeles
Oakland
Pasadena
Riverside
San Diego
San Francisco
San Jose
San Mateo
San Rafael
Ventura
Santa Maria
Watsonville

COLORADO
Colorado Springs
Denver

CONNECTICUT
Hartford
New Britain

DELAWARE
Wilmington

D. C.
Washington

FLORIDA
Fort Lauderdale
Jacksonville
Orlando
St. Petersburg
Tampa
Pensacola
Panama City

GEORGIA
Atlanta

IDAHO
Lewiston

ILLINOIS
Belleville
Benton
Bloomington
Chicago (3 outlets)
Evanston
Oak Park
Danville
Decatur
Elgin
Freeport
Granite City
Great Lakes
Jacksonville
Joliet
LaSalle
Mattoon
Pittsfield
Rockford
Rock Island
Springfield
Sterling

INDIANA
Anderson
Evansville
Fort Wayne
Indianapolis
LaFayette
LaPorte
Marion
Muncie
Terre Haute
Richmond

IOWA
Burlington
Clinton
Davenport
DesMoines

KENTUCKY
Paducah
Dawson Springs
Lexington
Louisville

LOUISIANA
Baton Rouge
Lake Charles
New Iberia
New Orleans

Worcester
Pittsfield

MICHIGAN
Battle Creek
Kalamazoo
Port Huron
Saginaw

MINNESOTA
Duluth
Hibbing
Minneapolis

Dubuque
Fort Dodge
Sioux City
Waterloo
Red Oak
Council Bluffs

KANSAS
Hutchinson
Junction City
Topeka

MAINE
Lewiston
Portland

MARYLAND
Baltimore
Cumberland

MASSACHUSETTS
Holyoke
Lawrence
Salem
Springfield

Hutchinson
Rochester
Winona

MISSISSIPPI
Greenwood
Hattiesburg

MISSOURI
Columbia
Joplin
St. Louis
Springfield

St. Joseph

MONTANA
Billings
Butte
Missoula

NEBRASKA
Grand Island
Hastings
Lincoln
Norfolk
Omaha

NEW MEXICO
Albuquerque
Deming

NEW YORK
Binghamton
Brooklyn
Buffalo
Elmira
Ithaca
Jamestown
Johnstown

OHIO
Cambridge
Canton
Cleveland
Dayton
Lima
Mansfield
Youngstown

OKLAHOMA
Enid
Oklahoma City
Tulsa

Harrisburg
New Castle
New Holland
Norristown
Philadelphia
Pittsburgh
Pottsville
Reading
Scranton
Warren
Williamsport
York

RHODE ISLAND
Providence

SOUTH CAROLINA
Charleston

SOUTH DAKOTA
Aberdeen
Lead
Sioux Falls

TENNESSEE
Knoxville
Memphis
Nashville (2)

TEXAS
Abilene
Amarillo
Harlingen
Corpus Christi
Dallas
Ft. Worth
Galveston
Houston
Lufkin
McKinney
Odessa
San Antonio
Texarkana
Wichita Falls

UTAH
Ogden
Salt Lake City

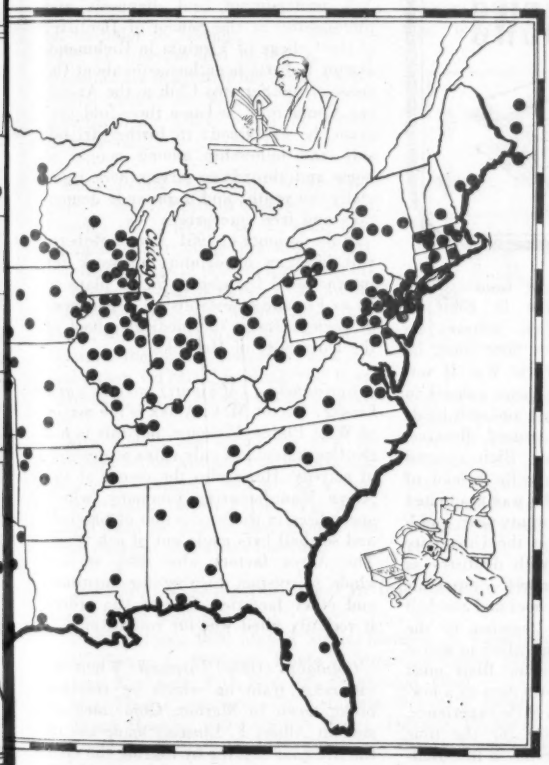
VIRGINIA
Lynchburg
Newport News
Richmond
Roanoke

WASHINGTON
Spokane
Tacoma
Walla Walla

WEST VIRGINIA
Charleston
Clarksburg
Parkersburg

WISCONSIN
Appleton
Beloit
Columbus
Fond du Lac
Jefferson
LaCrosse
Madison
Manitowoc
Milwaukee
Oshkosh
Racine
Sheboygan
Wausau

CANADA
St. John. N.B.
Vancouver, B.C.
Moose Jaw, Sask.
Saskatoon, Sask.
Prince Albert, Sask.
Halifax, N. S.
Winnipeg, Manitoba



NEW HAMPSHIRE
Manchester

NEW JERSEY
Asbury Park
Camden
Jersey City
Morristown
Passaic
Plainfield
Trenton

New York City (2)
Olean
Saratoga Springs
Syracuse
Utica
Watertown

NORTH CAROLINA
Asheville
Charlotte
Winston-Salem

NORTH DAKOTA
Bismarck

OREGON
Klamath Falls
Portland

PENNSYLVANIA
Altoona
Abington
Allentown
Bradford
Chambersburg
Easton
Erie
Hazelton

Dentists in the NEWS

Louisville (Kentucky) Courier-Journal: Because Critenden D. Blair of Flemingsburg, Kentucky, believes he will be called to active duty soon, he faces a dilemma. A World War II veteran, he was discharged as a colonel in the Quartermaster Corps, and still holds that rank in the Organized Reserve. However, after the war, Blair entered the University of Louisville School of Dentistry from which he was graduated in June, realizing a twenty-year ambition. He had enrolled at the University of Kentucky in 1930 with dentistry as his goal, but circumstances altered his course and he taught school and coached basketball until, as a member of the National Guard, he was called to active duty in 1940. Now Doctor Blair must decide whether to take up duty as a low-rank dental officer with little experience, or to abandon dentistry for the time being and return to service in the Quartermaster Corps as a colonel.

Denver (Colorado) Post: Doctor Ralph Roberts, international president of the Sertoma Service Club, recently made an inspection tour of the Club's 142 branches in this country and Canada. Originally called the Co-operative Club, its name was changed because of confusion with a left-wing party in Canada. Sertoma ("service to mankind") is the second oldest service club in the United States and plans to expand to other foreign countries.

A professor of oral diagnosis and therapeutics at the School of Dentistry of the College of Virginia in Richmond, Doctor Roberts is enthusiastic about the value of the Sertoma Club to the American Community. It has a three-fold program, he explained: to further friendship and fellowship among people at home and abroad; to serve others, especially the youth; and to promote democracy and free enterprise.

In the summer of 1951, Doctor Roberts will have an opportunity to work for international friendship, for he plans to fly to Finland to establish a department of periodontia at the medical school of the University of Helsinki.

Springfield (Missouri) News and Leader: Doctor M. C. Amyx is the mayor of West Plains, Missouri, but this is not the Ozark dentist's only extra-professional activity. He is also the owner of the Amyx Manufacturing Company, which specializes in the production of baseball and softball bats made out of ash wood. The Amyx factory also does various kinds of custom turning for furniture and other factories. One of the orders it recently filled was for rolling pins.

Columbus (Ohio) Dispatch: When the excursion train on which he traveled broke down in Marion, Ohio, medical student Albert F. Linscott made use of the five-hour layover by touring the city. His inventory showed that its 10,000 people were served by only six dentists. Upon his graduation from the University of Maryland medical school in 1900, Doctor Linscott was permitted to choose either medicine or dentistry as a profession. He returned to Marion and set up his dental chair. Now, at 73, he is still

active and practices there with his son, Doctor Albert O. Linscott.

Doctor Linscott is credited with a number of dental innovations during his long career. He wore the first white dental coat; used the first electric motor for drilling; and brought the first dental cuspidor to Marion, all in 1900. In 1920, he was the first to use an X-ray machine. He organized the Central Ohio Dental Society in 1912, and in 1915 he organized the Ohio Board of Dental Examiners.

Long Beach (California) Press-Telegram: Santa Barbara dentist, Doctor Charles R. Pierce, is a spare-time botanist. After eight years of experimenting, he has developed a new variety of cucumber that is sweeter and milder than standard types. White rather than green, the new salad delicacy is a cross between the lemon cucumber and several other varieties. Lacking the usual hard skin, it can be eaten like a candy bar.

Mrs. Pierce has tested the new cucumbers in her kitchen and reports that they make superior pickles. As a final selling point, Doctor Pierce says not a single case of gastric disturbance has been charged to his new product.

Flint (Michigan) Journal: After four days of playing in the Summer National Tournament of the American Contract Bridge League, the winners of the master pair world championship were Doctor C. W. Yorke, Flint, Michigan dentist, and his partner, Manuel Sherwin. "It was one of those times you play

and never expect to win," commented Doctor Yorke, after his recent victory over 190 other pairs in Columbus, Ohio. Winning the tournament entitles the players to hold a $10,000 gold trophy for one year. In addition, the Flint winners received a smaller trophy of their own choice.

Awards for items published in this month's DENTISTS IN THE NEWS have been sent to:

B. W. Gilbert, 1430 Mound Street, Madison 5, Wisconsin.
Mrs. Anna L. Swenson, Route 3, Mountain Grove, Missouri.
June R. Gregg, P.O. Box 105, Bainbridge, Ohio.
Mrs. Thad Cummings, 1770 Lafayette, Denver 6, Colorado.
Nancy Herring, 449 Lafayette Street, Jackson, Tennessee.
Elizabeth Merriehew, 1416 East First Street, Long Beach 2, California.

CAN YOU USE A DOLLAR?

TO EVERY READER who contributes a newsworthy item, something unusual about a dentist, *which is published in Dentists in the News*, we will send promptly a crisp, new one-dollar bill. Every clipping must be taken from a newspaper and carry the name of the publication and the date line. Clippings submitted cannot be returned. When more than one copy of a clipping is submitted, the first one received will be used. Send all items to Dentists in the News, ORAL HYGIENE, 708 Church Street, Evanston, Illinois.

You Think You are Insured

BY W. CLIFFORD KLENK

IF THE DENTISTS of the country were asked, "Do you carry personal accident insurance?" the reply would be almost 100 per cent affirmative. Query them further: "What type of contract have you? How long will it pay an income, if you sustain an ankylosed wrist or lose a hand?" The responses would bring to light the shocking but pardonable ignorance of the average dentist about this form of all-important coverage, its limitations, and inadequacies.

What are the dentist's needs? They stem from the peculiarities of his occupation. The word "his" bears remembering. Dentistry is a one-man business. When the dentist stops, his income ceases, temporarily or permanently. A permanent hand injury ends his professional career. In such an eventuality, his chances of rehabilitation in a new field are in inverse proportion to the number of years he has been at the chair. Thus he needs substitute income for the maximum possible period, whatever the injury and its consequences. It is not too much to ask that the income continue long enough to permit him to:

1. Become psychologically adjusted to his permanent misfortune, if such it is, and,

But do you understand fully the provisions and limitations of your insurance contracts?

2. Have adequate time to train in a new field, so as ultimately to approximate his former professional income.

Today he has no such protection. Two meaningful clauses in his policy, almost regardless of company, tell the story.

The Total Disability clause (Total Loss of Time) most widely offered for a score of years, reads thus: *"If such injury . . . shall wholly and continuously disable the insured and prevent him from performing any and every duty of his occupation . . . the company will pay the weekly indemnity for the period of such continuous disability, but not exceeding fifty-two weeks. Thereafter, the company will pay the same amount so long as the insured shall be wholly and continuously disabled . . . from engaging in any gainful occupation for wage or profit."*

"His" and "any" are the key words. "His" occupation is treating, restoring, extracting teeth; all manual duties. Permanently restricted manual function leaves the dentist, after a year, still unable to do dentistry, but definitely able to engage physically in other ("any") gainful occupations allied with dentistry. He can sell dental supplies, or act as consultant for a dental supply house. Like it or not, he will be unable to refute the company's reminders that he is physically able to be so employed, and that the company did not contract to pension him for life because he is now removed permanently from his chosen field. Thus, his accident benefits cease in one year. So reads his contract. It is axiomatic that the courts respect the provisions of a contract, in the absence of ambiguity. The clause quoted here is completely clear. Admittedly, for the run-of-the-mill injury, the sprained ankle or fractured rib, the clause works no hardship and is equitable. So, too, with the lifetime, all-crippling injury of the wheel chair variety. But, how often does such an injury occur among dentists?

Dismemberment Benefit

The second "benefit" whose implications are worthy of a fuller understanding is the Dismemberment Benefit (Capital Sum Losses). Doctor X carries $100 weekly benefit. He loses an arm "at or above the wrist." His contract pays a lump sum of $100 x 100 weeks, or $10,000, and twice this sum for a bilateral amputation. But these are rare. For a thumb *and* index finger—not one or the other—$100 x 50 weeks, or $5,000, is paid, and then generally in full discharge of the company's obligation. Loss of a thumb alone would end a dentist's career. I do not emphasize these *dismemberment benefits* because amputations are fre-

quent. They are not! Reference is made to them to point out the absurdity of these benefits as income protection for the amputee-dentist. When *dismemberment benefits* are found in contracts, purporting to have been designed especially for the dentist; when they are endorsed officially by dental societies, as they have been; one is constrained to ask, what price accident insurance?

Because of his manual dependency, the dentist is not considered a grade A risk. He pays almost 100 per cent more premium for the same weekly benefit than does the lawyer or office worker. With this in mind, as well as the fact that what the market offers is inadequate, what would be a fair solution?

Lifetime indemnity is the answer. It has not been available for a score of years, and nothing in the offing indicates its future availability. Certainly the dentist schooled only in his specialty, is entitled to a weekly income through accident insurance for at least five years without the pettifogging verbiage, lump sum payments, or the "frills" so common to accident insurance; for example, double benefit if injured "by the collapse of the outer walls of a building," and other unlikely happenings.

The occasional dentist, troubling to learn the inadequacy of the average accident policy offered to him, scours the market and finds himself in a maze of contradictory premium quotations. He concludes (1) he can pay about $45 yearly for $50 weekly income for one year, with the lifetime "frill" included and lump sums for dismemberment; or (2) the same $45 will buy $50 weekly for 300 weeks and no longer on the sole condition that he cannot do dentistry, but with dismemberment payments paid in lump sums; or (3) $30 a year buys him $50 weekly for five years (260 weeks) with a partial disability weekly benefit for any portion of the five years he is not totally disabled. Inconsistently, the higher cost contracts at the rates here used do not include any partial disability benefit, unless the $45 charge is upped to about $63. Favoring the contract paying for the longer period of occupational disability, but confused by the rate inconsistencies, the dentist too often decides to retain the accident insurance he has carried for years, confident that, because it paid gracefully for his fractured leg some years ago, it will serve him equally well should a hand or any other injury end his professional career. Further, he has tucked away in his mind the fallacious belief that the permanent disability clause of his several old life insurance policies will serve him in any real injury crisis. How wrong he is! His life insurance with disability income would not pay him a cent if he lost an

(*Continued on page* 1637)

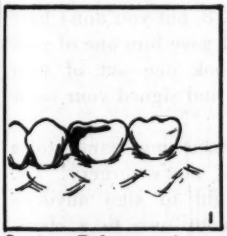
TECHNIQUE of the Month

Conducted by W. EARLE CRAIG, D.D.S.

Drawings by Dorothy Sterling

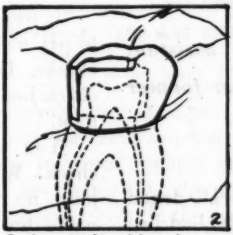
Pulpotomy for Deciduous Teeth

BY WILLIAM J. BARTRAM, D.D.S.

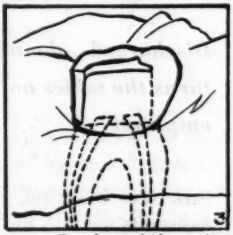


Caution: Pulpotomy is only successful on healthy pulps. Determine, before proceeding, if the tooth has ever ached.

Deciduous first molar: deep caries. Anesthetize.



Isolate with rubber dam or cotton rolls. Remove all caries and expose pulp.



Cut off pulp at bifurcation and stop bleeding with epinephrine hydrochloride. (Heat from bulb on dental unit will also stop bleeding.) All bleeding must be stopped.

Mix a paste of calcium hydroxide (slaked lime) with sterile water and flow over pulp stump. Remove excess moisture with cotton pledgets.

Flow crown and bridge cement over calcium hydroxide and allow to set. Shape up as a regular base.

Remove rubber dam and proceed with restoration in regular manner.

The Perfect Retort

BY A. RANDALL RUSKIN, D.D.S.

Discharged dental assistant turns the tables on her former employer.

SHE WAS beautiful, as all dental assistants seem to be. She had just obtained her Bachelor of Arts degree from one of our leading women's colleges, and the position in my office was her first.

When I returned from lunch on the second day of her employment, my young assistant informed me that a delivery man from a department store had been in with a C.O.D. package.

"That's too bad; I knew he was coming and I should have left you the money to pay him."

"Oh, that's all right," she replied; "he left the package."

"It's strange that he would leave the package without collecting any money. I have no charge account at that store."

"But, Doctor, I paid him for it."

"Well, that was considerate of you. Before you leave tonight, remind me to reimburse you. How much was it?"

"It was $18, but you don't have to pay me. I gave him one of your checks. I took one out of your check book and signed your name to it."

"You signed my name to a check! Why, that's forgery! You have no right to sign anyone's name but your own to a check. That certainly was a stupid thing to do."

Completely exasperated, I paid her for the week and let her go at once.

That very evening, my wife and I were walking down Broadway, and managed to edge our way into a crowd gathered in front of Loew's State Theater. It was a radio program called, "The Man On The Street," in which the passing pedestrians were interviewed and quizzed.

Suddenly, the announcer pushed the microphone toward me, asked my name and address, and proceeded to ask me the nicknames of different States of the Union.

At the mention of New York State, I proudly answered, "The Empire State," and also knew that Connecticut was the "Nutmeg State;" but that was about the limit of my knowledge insofar as that particular subject was concerned.

In rapid succession came Nevada, Colorado, Utah, Idaho and Montana; and to each I had to answer, "I don't know."

When I arrived at my office the next morning, fan mail was awaiting me. It was in the nature of one postal card, signed by my erstwhile secretary and read: "Dear Doctor, I heard you on the radio last night and you're not so smart, either."

271 *North Avenue*
New Rochelle, New York

YOU THINK YOU ARE INSURED

(*Continued from page* 1634)

arm or was otherwise totally and permanently disabled *only* for the duties of his profession. In truth, probably he never read any policy he bought. If he is the average insurance buyer, he trusts to luck, confident that because a large well-known company insures him, he will be well treated. No doubt he will, but only within the limitations and provisions of his contract. Personal accident insurance, as commonly offered by most companies to the dental profession today, is, in the event of a protracted or permanent occupational disability, of little more value than a broken crutch to a cripple.

295 *Madison Avenue*
New York, New York

WHEN YOU CHANGE YOUR ADDRESS

WHEN YOU change your address, please always furnish your old address as well as the new one. If your post office has zoned your city, the zone number should be included. Please send address change promptly to ORAL HYGIENE, 1005 Liberty Avenue, Pittsburgh 22, Pennsylvania.

EDITORIAL COMMENT

"Give me the liberty to know, to utter, and to argue freely according to my conscience above all liberties." *John Milton*

MILITARY DENTISTRY CAN BE BETTER

DRAFT LEGISLATION for dentists has made the country conscious of the heavy dental demands of our armed forces. How these needs are met and the character of the service rendered should be of interest to the public. The profession should oppose the use of the mass production, assembly-line type of dentistry that was done in many military installations during the last war. There was too much emphasis on quantity production and not enough on quality. Dentists were graded on the basis of how much they produced at the chair every day and not on what kind of service they rendered.

The unknown author of the mass production dental system in the military establishment has never stepped forth to claim his ignoble tribute. Whoever it was, confused dentistry with the production of armaments. To boast of the number of teeth extracted and the number of "fillings" placed in a given time is a discredit to the profession of dentistry. The awful aftermath of this system has been seen in the dental demands of the Veterans Administration since the end of the war. In one year ending June 30, 1948, the Veterans Administration paid more than $50,000,000 to dentists in private practice to cover treatments of veterans for service-connected disabilities. A large share of this expenditure could have been saved if the dental services were performed properly in the first place.

Whoever was responsible for the conditions under which dental officers worked in World War II is not now a matter of importance. That they were subservient to medical corps officers, that some of our ranking dental officers were men of small vision who made dentists operate under a system of speed-up and mass production, are sorry facts of history. The dental officers themselves were of the cream of our

dental colleges. They were well trained and prepared to deliver the best kind of dental care. They were compelled to perform dentistry far inferior to their training and skills. The men who are now being called to service should be assured that they will not be compelled to operate under the same kind of conditions.

What may be done to assure dentists who will be required to serve in the armed forces that they will not be expected to render dental treatments that are inferior to their skills?

First, the Secretary of Defense should appoint a commission of respected civilian dentists to set up dental standards for the armed forces. Such a commission would not supplant the dental heads of the Army, Navy, and Air Force. The commission should work with the regular heads of the military dental services and back them with public and congressional opinion to assure them that medical corps domination will no longer exist in the dental service. This group of civilian dental advisors should be directly responsible to the Secretary of Defense and not to the chief of the medical services.

Second, dentists who enter the military should be assured that they will not be required to operate under a primitive, mass production system but will be permitted to exercise their skills in diagnosis, oral surgery, operative and prosthetic dentistry, periodontia, and preventive dentistry.

Third, dentists should be assured that they will function in their professional capacities and that they will not be expected to perform as transportation and recreational officers, treasurers of the officers' club and mess, and take on other miscellaneous duties. Presumably, the need is great for dentists to function as dental officers. Extraneous and auxiliary activities should be discouraged except in the face of emergencies.

Several thousand of our colleagues will be closing their offices in the next few months to enter military service. It will be tragic for them and the profession if we do not back them to the limit to assure them that they will function under conditions that are not degrading to them and to the profession that they represent.

Edward J. Ryan

Telephone Tips for the Dental Office

BY ROBERT F. WELCH

THE DENTAL profession owes a sincere debt to a pioneer who not once held an explorer or forceps in his hand. Alexander Graham Bell probably has done more to promote the cause of sound teeth than any man without a degree in dentistry.

As with all forms of human communication, the telephone requires conscientious attention if we are to get the utmost potential from it. Dentists sometimes take the instrument so much for granted that they do not realize what a tremendous factor it can be in promoting efficiency and good will.

The dentist with a well-modulated voice, whose words emerge from the receiver charged with confidence, has a valuable professional asset. And it happens to be one which all of us can develop if we care to. Not that you should seek to imitate the suave tones of a radio announcer. After all, the telephone is intended for conveying messages—not for entertainment.

Frank answers to the following questions will reveal whether you and your staff are using your telephone efficiently:

1. Do you speak in a pleasant, normal tone of voice?

2. Is the mouthpiece about half an inch from your lips, held so you talk directly into it?

3. Do you watch inflections so there will be no confusion at the other end of the line? When your receptionist says, "Doctor Jones' *office*," she does not anticipate the patient's train of thought. It is much better to accent the dentist's name—the patient knows she is calling an office.

4. Do you speak slowly and dis-

Try this telephone courtesy test and check for deficiencies in your office.

tinctly so each word is understood? Speed is probably the biggest drawback to proper telephone communication. Busy dentists sometimes forget that their every word is important to the listener.

5. Does your receptionist or assistant have pleasant surroundings in which to work? She will create a better impression if she is comfortable and at ease.

6. Is she free to give each caller the attention he deserves? When she is burdened with extra duties, she will resent telephone interruptions and her voice will show it.

7. Is she natural instead of formal in her conversation? "I'll see" is better than "I shall see." People like to be talked to as they would speak themselves.

8. Does she avoid arbitrary expressions? The statement, "You will have to call back when Doctor Jones is in," can be improved by courteously asking the person to call at a specified time.

9. Do you hold yourself remote? Insisting that all calls be screened even when you are free to take them is an unnecessary precaution. If a patient calls for information, you can save time by getting it while somebody else digs out the case history.

10. Does your receptionist have sufficient information at her fingertips? She should not only know about all appointments, but other plans which may take up your time in the immediate future.

11. Are you careful to return all calls immediately after reaching the office, or do you wait to be called again?

12. Successful public speakers frequently practice in front of the mirror—why not suggest this for your staff?

13. Do you make occasional test calls from outside to see just what kind of reception other people are getting?

14. Why not give your telephone operator the free help and literature provided by your local telephone company's business office?

2708 *Granada Avenue*
San Diego 4, *California*

IF YOU ENTER MILITARY SERVICE

IF you are called to military service, please be sure to send us your new address, and address changes as they occur, so that we may continue to send you ORAL HYGIENE. Please address ORAL HYGIENE, 1005 Liberty Avenue, Pittsburgh 22, Pennsylvania.

ASK Oral Hygiene

Please communicate directly with the department Editors, V. Clyde Smedley, D.D.S., and George R. Warner, M.D., D.D.S., 1206 Republic Building, Denver, Colorado, enclosing postage for a personal reply.

Ridge Resorption

Q.—I am sending you some roentgenograms for diagnosis and treatment recommendation for a 32-year-old man in good physical condition.

All his teeth were removed in 1940 with a general anesthetic, and a questionable alveolectomy. The patient reports that the bone continued to work out of his gingivae for approximately one month after extraction. After about three weeks of healing a set of dentures were constructed for him. These dentures apparently served satisfactorily for a year and a half, at which time they were relined. In 1947, the dentures were so uncomfortable he had to have them changed. He says that his bite extended too far laterally and that he was unable to masticate his food properly.

The patient complained to me of pain and irritation in the inferior incisor region; also some pain and intermittent swelling in the left maxillary region.

The patient's gingivae appeared red, somewhat swollen, and rather flabby. There was evidence of irritation in the left maxillary region and the lower incisor region. The ridges in general are not too well formed for dentures, having numerous irregularities. So far as vertical dimension is concerned, the dentures appear to be all right when inserted. However, the lower denture does not cover the area it should, particularly the retromolar fossa. This has caused an extrusion of the retromolar tissue over the posterior border of the lower denture.

In my opinion, the patient's condition is mainly the result of ill-fitting dentures, which have caused an osteitis of the cortex of both the maxilla and the mandible.

Would you give me your opinion as to the diagnosis and treatment of this patient?—A. E. B., Colorado.

A.—I agree with you that poor fitting dentures are a causative factor in excessive ridge resorption such as this case presents. In my experience, however, this is not necessarily the whole cause of such a condition. I made seven denture fittings (either rebasings or new dentures) during a period of five years for one patient who stands out in my memory. Each case was fitted to the best of my ability when it was made, but despite everything I could do the bone of his jaws continued to melt away with unbelievable rapidity.

You cannot safely make this man any promises that you can stop the progress of this condition with new dentures. We have satisfied a great many patients, temporarily at least, who have come to us with knife or saw tooth bony

ridges, such as this mandible presents, by making new dentures over a prepared cast of the mouth. This preparation consists of simply cutting the high narrow ridge down on the cast to a flat enough and broad enough base so that what bone is left will be nourished properly, and where the sharp crest of bone will not cut and bruise the gingivae from underneath the moment the slightest pressure is put upon it.

Your roentgenogram of the left maxillary molar region seems to show two small root fragments which no doubt should be removed. —V. CLYDE SMEDLEY.

Sensation of Dryness

Q.—I have a patient for whom I recently rebased an upper denture and made a lower partial. He has had three upper dentures, which he could not wear because they seemed to cause excessive dryness of the mouth and upper lip. When he does not wear the dentures, he says the flow of saliva is excessive. Do you know of any treatment for such a condition?—C. A. L., South Carolina.

A.—Your patient's sensation of dryness of his mouth and upper lip with his upper denture in place, I believe, would correct itself if he could be persuaded to persist in wearing them continuously for several weeks; especially since he has an ample flow of saliva when the denture is out. It would seem wise to reduce the vertical opening and the denture fullness under the lip in such a case.

The real solution to this problem is probably that your patient must cooperate and persist in wearing the dentures until he becomes thoroughly accustomed to their presence in his mouth, at which time his saliva flow and all other functions will be normal.—V. CLYDE SMEDLEY.

Loose Dentures

Q.—I have a patient, an automobile mechanic, age 35, for whom I recently constructed an immediate full upper denture. I extracted his posterior teeth first, and several months later, after extracting the six remaining anterior teeth, inserted the immediate denture. The patient wore this immediate denture for almost four months, at the end of which time I rebased the denture. The patient had considerable shrinkage and had to use denture powder before the rebase. He has worn the rebased denture now for a little over a month, but has been back several times complaining of the denture loosening after being in the mouth for about an hour. He complains also of an excessive amount of saliva under the denture. (In his words, he feels as if he had a wet sponge under it.)

I have checked the denture for occlusion and relieved all muscle tension, but still am unable to account for the loosening or the accumulation of saliva. The patient has most of his own lower teeth. However, they are broken down and carious, and he requires a denture there as well.

My problem is whether I am at fault, or is this condition caused by some other physical condition? I should appreciate your suggestions as to what course to follow.—S. J. K., New Jersey.

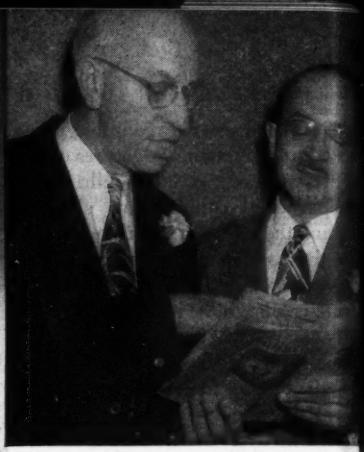
A.—The loosening of an upper denture that occludes with irregular, partly missing, or carious low-

(*Continued on page* 1646)

Portraits and Profiles

Of American Dentists

By Howard A. Hartman, D.D.S.



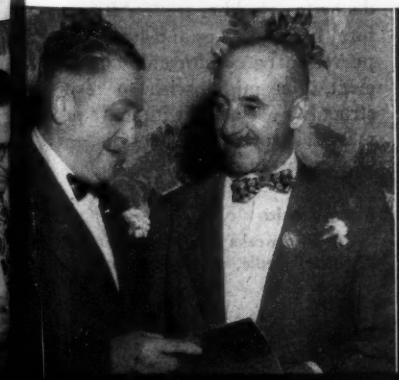
Harold S. Horton (left) of Brooklyn, Chairman of Press and Publicity; with Joseph L. Riesner, Chairman of Topic Discussions at the Greater New York meeting.

Donald H. Miller, Elmira, New York, Vice President of the New York State Dental Association; and Albert J. Abeloff of Brooklyn, President of the New York Second District Dental Society.

Above: Left to right: Harry Reisman, Chairman of Exhibits; Francis X. McHugh, President of the New York First District Dental Society; and Jacob Fineman, Chairman of Entertainment; all of New York City.

Right: Shown at the American Dental Association meeting in San Francisco are Leslie A. Wingfield of Los Angeles and J. Merle Kinstle (right) of Cleveland, Ohio.

Below: Willard S. Bell, Jamaica, Advisory Chairman of the Greater New York Dental Meeting, with K. Neil Donally of New York City, Chairman of the meeting.



Below: Chairmen of Registered Clinics of the Greater New York Dental Meeting are Arthur E. Corby (left) of New York City, and Matthew Besdine, Brooklyn.

ASK ORAL HYGIENE

(*Continued from page* 1643)

er teeth is likely to be caused by an unbalanced, dislodging occlusion; though some mouths resorb much more rapidly than others regardless of the occlusion.

Tell this man not to allow himself to be too much disturbed by the accumulation of saliva under his denture. If it were not for the moisture under our dentures they would not stay in at all. The layer of moisture between the denture and the gingivae causes adhesion of a denture to the mouth. The same principle applies to the molecular adhesion that holds two pieces of plate glass together when they are wet, but lets them drop apart when they are dry. If excess saliva collects above a denture, it is easy to remove it by sucking and swallowing.—V. CLYDE SMEDLEY.

Grinding Anterior Teeth

Q.—During recent examination of a 45-year-old patient, I noticed her lower centrals and laterals were worn down on the incisal edge. In centric occlusion these lower anterior teeth do not touch the lingual surface of the upper centrals and laterals; but when the lower jaw is protruded in an edge-to-edge bite, she contacts the incisal edges of upper centrals and laterals with the lower centrals and laterals. She says that under tension she throws her lower jaw forward and grinds on her anterior teeth. Also she has been told that she grinds her teeth when she is sleeping. The incisal edges of the upper centrals and laterals are chipped and jagged, probably as a result of this edge-to-edge grinding.

If models would give you more material with which to work on this case, I certainly should be glad to forward them.

This patient is our local school oral hygienist and is concerned about the abrasion of the incisal edges.—L. H. W., Pennsylvania.

A.—Complete casts and roentgenograms of this woman's complete dentition certainly would make an intelligent diagnosis more possible. But I am inclined to think from your description of the case that the difficulty could be met, at least for the time being, by fitting her with an occlusal splint covering the occlusal surfaces of the posterior teeth either on the upper or lower jaw or possibly both jaws. These splints should be built to a balanced functional bite that will clear the chipped incisors from abrasive contact in the incisive position.

She should wear the splint or splints at night and also during the day until she overcomes the tendency to grind her teeth. After this bite has been established, if it proves to be comfortable and efficient, you might wish to reconstruct her occlusion with more permanent work than acrylic.—V. CLYDE SMEDLEY.

Paresthesia

Q.—Two weeks ago, using a one-inch 27-gauge needle, I made an injection

for the removal of a lower right first molar and obtained perfect anesthesia with 2 per cent procaine solution with epinephrine 1:50,000. The tooth was removed without effort. It had no abscess and was removed because caries had reached the pulp chamber.

Two days later, the patient reported for examination and complained of numbness on the upper right side of his face and inability to wink or close the upper eyelid.

I felt no resistance to the plunger on making the injection and cannot account for the reaction. Could it be that I injected into the nerve proper or just under the nerve sheath where the procaine is trapped and cannot escape?

The patient has noticed a slight improvement in the last two days. —F. E. G., Massachusetts.

A.—Without much doubt your needle entered a vein when you made the mandibular injection of procaine for the removal of a first molar. The anesthetic was carried to the pterygoid plexus through the venous circulation, and it is not difficult to understand how the paresthesia of the tissues named ensued.—GEORGE R. WARNER.

Dryness of the Mouth

Q.—I have a case which puzzles me and I should appreciate your advice.

I have constructed an upper unilateral cast skeleton partial denture finished in acrylic, together with a similar lower partial case replacing the second right bicuspid, the first molar on the right side, and the first molar on the left side. The patient's bite was opened approximately two millimeters.

Both dentures fit well, but the patient complains of an extreme dryness in his mouth which causes his tongue to feel thick. This hampers his speech and, since his work entails considerable speaking, this condition has made him extremely nervous to the point of making him vomit toward the end of the day.

The patient has consulted a physician whose report is negative. When the dentures are removed the flow of saliva returns to normal within approximately 12 to 48 hours. Could the opening of the bite cause this dryness and nervousness? —J. S., Michigan.

A.—How could you open the bite with the partial dentures involving so few teeth? I am convinced that bites should never be opened with dentures unless all available teeth are involved in the occlusal support and occlusal splints are combined with the partial denture to provide a balanced functional bite.

If you have opened this man's bite with too few teeth carrying the stress this could produce a trauma or nervous strain with dryness of the mouth as one of its manifestations.—V. CLYDE SMEDLEY.

Orange Stains

Q.—I cannot seem to cope with these two problems and I should appreciate your aid:

1. A boy of eight gets orange stains on his teeth continuously, especially on the lower anteriors. I can clean them easily, but a few days later the stains return.

2. Following removal of cystic ovaries, a woman of forty reveals teeth that decay or virtually hollow out. The disintegrated dentine is soft, mushy, and even absent. The carious tooth, if it may be called such, seems like a pearl with the gelatinous substance removed.

No doubt there is a metabolic disturbance affecting the calcium. The onset seems sudden and self-limiting. It

seems to arrest itself close to the pulp chamber.—R. F., New York.

A.—Your question about orange stains is a new one. We have had many kinds of stains with which to contend, but we have had no experience with orange stains, nor can I find anything in the literature about them. We know that workers in the orange groves who suck oranges suffer a decalcification of the labial enamel of anterior teeth. If this boy drinks orange juice or eats oranges that have been cut up, I cannot account for the stains.

It has been shown that there can be a relation between female hormones and the soft tissues of the mouth,[1] but I do not know of a relation between the female hormones and the hard tissues of the mouth. It would seem, therefore, that the caries from which your patient is suffering is not related to the removal of her ovaries. Your thought about a metabolic disturbance being in causal relation to the peculiar type of caries is probably right.—GEORGE R. WARNER.

Thymol vs. Phenol

Q.—I wish to use thymol instead of phenol for sterilization of cavities. What strength of thymol is to be used? And does thymol need a follow-up of alcohol as does phenol?—W. G., New York.

A.—You are wise to change from phenol to thymol for cavity sterilization. One writer[2] has found that thymol crystals melt at 51.5 C. and he used the melted crystals for cavity sterilization. He noted that "a few crystals will remain in the porous dentine, but the cavosurface margins will be free," after the liquid thymol is blown out of the cavity. This writer says, "Thymol is 23.4 times stronger than phenol and its action is not self-limiting or caustic, and there is no discoloration."—GEORGE R. WARNER.

Aphthous Stomatitis

I believe your inquirer (H.W.G.)[3] described a condition known as chronic intermittent aphthae (as opposed to habitual aphthae), and which was first described by Mikulicz in 1888. This disease occurs primarily in women and not infrequently has its onset at the time menstruation begins. It tends to recur at intervals of from four to six weeks and the lesions are quite compatible with those described in the case of the above mentioned.

In the November 1936 issue of the *Journal of the American Dental Association* appears an article of mine dealing with the treatment of these lesions. I regret that I have no more reprints, but the treatment is simple. When the patient experiences premonitory symptoms, he immediately commences the use of purified bone phosphate tablets of approximately

[1]Ziskin, D. E.; and Zegarelli, Edward: Clinical and Histopathological Study of Desquamative Gingivitis and Its Treatment with the Sex Hormones, J. D. Res. **21**:341, 1942.

[2]Day, H. W.: Thymol in Cavity Sterilization, JADA **31**:605 (May 1) 1944.

[3]Ask Oral Hygiene: "Habitual Aphthae", ORAL HYGIENE, **39**:1372 (September) 1949.

Steele's IS THE WORD

FOR THE BEST TEETH

FOR ANY METAL RESTORATION

Steele's has provided for you, Doctor, a choice of teeth best suited to any type of bridge or metal restoration. Both facings and Trupontics are available in a wide choice of molds and in all New Hue shades. While for some restorations facings are undoubtedly indicated, in many others the Trupontic tooth offers important advantages.

Trupontics restore the full lingual portion of the lost teeth. They thus not only appear like natural teeth but feel that way, too. This natural "feel" is often important to the patient's speech. And, there being no recess at the ridge, a Trupontic bridge restoration is more sanitary.

Wherever one of these advantages can be obtained Trupontics will provide your patient with the utmost satisfaction. In bridgework, a Trupontic can be used in almost any case where a facing can be used. Note the extreme short bite case illustrated.

THE COLUMBUS DENTAL MANUFACTURING CO.
COLUMBUS 6, OHIO

1 gram each. Four of these are used daily and the lozenge is either chewed or allowed to dissolve in the mouth. Quite often this will abort the lesions. I have followed up several cases and the percentage of positive results is significant. These lozenges are prepared by the Upjohn Company and are called Purified Bone Phosphates. I do not know how the cure is brought about, but I have a suspicion that the high fluoride content may be the factor.—JAMES D. GRACE, D.D.S., 104 S. W. Trick Building, Ann Arbor, Michigan.

SO YOU KNOW SOMETHING ABOUT DENTISTRY!

ANSWERS TO QUIZ LXXIV

(See page 1623 for questions)

1. (c) on the cuspal surfaces of the molar teeth. (McBride, W. C.: Juvenile Dentistry, ed. 4, Philadelphia, Lea & Febiger, 1945, page 80)
2. (c) a significant change. (Accepted Dental Remedies, ed. 15, American Dental Association, 1950, page 114)
3. Gelatinous deposits found adhering to the teeth apparently formed by the deposit of a film of denatured mucin from saliva. (Leicester, H. M.: Biochemistry of the Teeth, St. Louis, C. V. Mosby Company, 1949, page 260)
4. (a) widens. (Sicher, Harry: Oral Anatomy, St. Louis, C. V. Mosby Company, 1949, page 119)
5. (a) greater. (Lane, J. R.: A Survey of Dental Alloys, JADA **39**:430 [October] 1949)
6. No—the process of eating results in a temporary drop in the oral bacterial count. (Pelton, W. J.; and Wisan, J. M.: Dentistry in Public Health, Philadelphia, W. B. Saunders Company, 1949, page 115)
7. No. (Thoma, K. H.: Oral Surgery, Vol. 1, St. Louis, C. V. Mosby Company, 1948, page 29)
8. No. (Brussell, I. J.: Temporomandibular Joint Disease: Differential Diagnosis and Treatment, JADA **39**:553 [November] 1949)
9. True. (Mead, S. V.: Oral Surgery, ed. 3, St. Louis, C. V. Mosby Company, 1946, page 893)
10. (a) the square. (Grossman, L. I.: Handbook of Dental Practice, Philadelphia, J. B. Lippincott Company, 1948, page 328)